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ABSTRACT

It is widely accepted that an increase in delinquency and violence is rooted in a number of interrelated social problems such as child abuse, alcohol and drug abuse, and youth conflict and aggression. Family strategies and interventions have been designed in an attempt to strengthen the role of the family within the community as a means to combat delinquency. The brief strategic family therapy model, presented in this document, integrates theory with decades of research and practice from the University of Miami. The theory has been adapted by the Spanish Family Guidance Center, also in Miami. In implementing brief strategic family therapy to the needs of these clients, the Center took into account the strengths and weaknesses these minority youth and their families bring to therapy and the special risk and protective factors they possess. This document discusses program objectives, target populations, theoretical underpinnings, components of intervention, and implementation of brief strategic family therapy, using the Spanish Family Guidance Center as a model. It also presents the development of a culturally specific family approach therapy. (Contains 2 figures and 25 references.) (JDM)

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U.S. Department of Justice
Office of Justice Programs
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ED 450 318

Brief Strategic Family Therapy

Michael S. Robbins and José Szapocznik

The Office of Juvenile Justice and Delinquency Prevention (OJJDP) is dedicated to preventing and reversing trends of increased delinquency and violence among adolescents. These trends have alarmed the public during the past decade and challenged the juvenile justice system. It is widely accepted that increases in delinquency and violence over the past decade are rooted in a number of interrelated social problems—child abuse and neglect, alcohol and drug abuse, youth conflict and aggression, and early sexual involvement—that may originate within the family structure. The focus of OJJDP's Family Strengthening Series is to provide assistance to ongoing efforts across the country to strengthen the family unit by discussing the effectiveness of family intervention programs and providing resources to families and communities.

The 1970's witnessed a tremendous increase in the number of Hispanic adolescents involved with drugs. In response to this problem, the University of Miami (FL) School of Medicine, Department of Psychiatric and Behavioral Sciences, established the Spanish Family Guidance Center in Miami to provide services to the local Hispanic community, which was predominately recent immigrants from Cuba. The Center was initially funded by the U.S. Department of Health, Education, and Welfare, Office of Economic Opportunity.

One of the first challenges the Spanish Family Guidance Center's clinical program encountered involved identifying and developing a culturally appropriate and acceptable treatment intervention for Cuban youth with behavior problems. To understand Cuban culture and how it resembled, and differed from, mainstream culture, the Center's staff conducted a comprehensive study on value orientations. The study determined that the Cuban community expected a family-oriented approach in which therapists take active, directive, present-oriented leadership roles (Szapocznik, Scopetta, et al., 1978).

The Center's second challenge involved developing interventions to help recent immigrant Hispanic families work together to deal with the stress of acculturation. In these families, it was quite common for conflicts to emerge or intensify when the children or adolescents began to behave in ways that were not consistent with the families' traditional cultural values. Typically, these conflicts occurred as children and adolescents assimilated more rapidly than their parents to the bicultural environment in which they were living, and often involved a clash between the American value of individualism and the Hispanic value of familism. Such intergenerational (parent versus

From the Administrator

Just as a child is influenced by his or her family, the child's family, in turn, is affected by the culture of which it is an integral part. If we are to succeed in preventing and combating delinquency, we must work to strengthen the role of the family within the community in which it resides.

This Bulletin features a family-strengthening strategy—brief strategic family therapy—that integrates theory with decades of research and practice at the University of Miami in an intensive, short-term, problem-focused intervention, generally lasting 3 months.

The Bulletin also describes the therapy's implementation by the Spanish Family Guidance Center. The Center, which was established by the University of Miami's School of Medicine, serves the local Hispanic community, consisting largely of Cuban immigrants. In adapting brief strategic family therapy to the needs of its clients, the Center took into account the strengths and weaknesses these minority youth and families bring to therapy, and those special risk and protective factors are also highlighted in these pages.

The needs of families are addressed most effectively within the social and cultural milieus of those families. Brief strategic family therapy is a time-tested approach to that end.

John J. Wilson
Acting Administrator

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adolescent) and cultural differences often yielded intense conflict within the family and resulted in parents and adolescents feeling alienated from one another.

In 1975, the Spanish Family Guidance Center adopted structural family therapy (SFT) as its core approach, and SFT has been at the heart of the Center's efforts to develop interventions for use in culturally diverse contexts (Szapocznik and Kurtines, 1993). Over time, the structural approach of SFT has been refined to meet the needs of the Hispanic community in Miami. For example, SFT uses treatment methods that are both strategic (i.e., problem focused and pragmatic) and time limited. Thus, the structural approach has evolved into a time-limited, family-based approach that combines both structural and strategic interventions. This approach, called brief strategic family therapy (BSFT), has become the most common intervention used by the Spanish Family Guidance Center for families that include youth with behavior problems.

BSFT evolved from more than 25 years of research and practice at the University of Miami. The structural orientation of BSFT draws on the work of Minuchin (Minuchin, 1974; Minuchin and Fishman, 1981; and Minuchin, Rosman, and Baker, 1978), and the strategic aspects of BSFT are influenced by Haley (1976) and Madanes (1981). By integrating theory, research findings, and clinical practice, BSFT has been continuously refined to improve its effectiveness with youth with behavior problems.

Since its modest beginning in a small storefront location, the Spanish Family Guidance Center has grown in response to the needs of the minority community in Miami. In particular, work with youth with behavior problems has expanded to include minority families from a variety of backgrounds, including both Hispanic (from the Caribbean Islands and Central and South America) and African American youth and families. To accommodate this expansion, the Center for Family Studies was established as an umbrella organization to serve inner-city minority youth and families in Miami. The mission of the Center for Family Studies is to identify the needs of minority families and develop and refine culturally appropriate interventions to meet those needs. The Center for Family Studies uses BSFT to help children and adolescents with conduct, delinquency, and other behavior-related problems, including alcohol and substance abuse. To improve youth behavior, BSFT attempts to change family interactions

and cultural/contextual factors that influence youth behavior problems. BSFT is based on the fundamental assumption that the family is the "bedrock" of child development; the family is viewed as the primary context in which children learn to think, feel, and behave. Family relations are thus believed to play a pivotal role in the evolution of behavior problems and, consequently, they are a primary target for intervention.

BSFT recognizes that the family itself is part of a larger social system and—as a child is influenced by her or his family—the family is influenced by the larger social system in which it exists. Sensitivity to contextual factors begins with an understanding of the influence of peers, schools, and neighborhoods on the development of children's behavior problems. However, BSFT also focuses on parents' relationships with children's peers, schools, and neighborhoods and on the unique relationships that parents have with individuals and systems outside the family (e.g., work or groups such as Alcoholics Anonymous).

Program Objectives

BSFT has been revised to respond to the unique strengths and weaknesses minority youth and families in Miami bring to therapy. Several of these risk and protective factors are described below.

Mitigating Risk Factors

Immigration. Many of the families served by the Spanish Family Guidance Center have recently immigrated to the United States. The immigration process creates specific problems that must be addressed in treatment. For example, many families emigrate in stages; it is not uncommon for one parent, usually the mother, to come to the United States alone to establish a place and economic means for the family, and then bring the children to this country. For many families, this process is protracted, and they are separated for many years. Moreover, the reunification process often fails to meet family members' expectations. Children are often disappointed when they arrive in the United States and see that they are living in an impoverished, dangerous, inner-city community. Likewise, parents are often disappointed when they are confronted with angry and emotionally detached children. As a result, treatment often involves attempting to reestablish parent-child bonds and create new family structures that include the parent who was separated from the family.

High conflict. Intense and persistent conflict is a common characteristic of families of youth with behavior problems. High levels of conflict interfere with parents' ability to resolve problems, communicate effectively, nurture, and guide their children. BSFT focuses on assessing the family's conflict resolution style and developing specific interventions to help families negotiate and resolve their differences more effectively.

Inner city. The powerful influence of neighborhoods cannot be ignored when working with inner-city youth and families. In fact, accumulating evidence shows that the positive changes made in family therapy are often overwhelmed by the harsh and deteriorated conditions of the inner city. As a result, the focus of BSFT has expanded from individual families to include the relationship between families and the multiple systems that influence children. Developments in the clinical model have been heavily influenced

by the theoretical work of Urie Bronfenbrenner (1977, 1979, 1986) and the groundbreaking clinical work of Scott Henggeler and his colleagues (Henggeler and Borduin, 1990; Henggeler, Melton, and Smith, 1992). In particular, BSFT has expanded to include attention to the relationship between families, on one hand, and schools, peers, juvenile justice agencies, and neighborhoods, on the other.

Enhancing Protective Factors

Extended families. One of the most effective protective factors is the availability of strong extended family networks. It is not uncommon, for example, for treatment to include grandparents, aunts, uncles, cousins, or even close friends ("fictive kin") who grew up with the child's parents. Although these networks may also be sources of problems for the family, they are frequently sources of strong support. In BSFT, these networks are often used to bolster or serve the important functions of the family. For example, extended family members are frequently engaged in treatment to help monitor the children while parents are at work. At times, members of the extended family or fictive kin assume primary leadership roles in the family when parents are unable or unwilling to perform these tasks. In most instances, BSFT seeks to strengthen social connections by increasing mutual support and decreasing tension and conflict between the family and the extended support network.

Family focus. A second protective factor that has helped minority families in Miami is their strong sense of family unity. Highlighting the needs of the family above the needs of individual family members motivates many adults to participate in interventions. In fact, the Spanish Family Guidance Center initially selected a family approach because of the Cuban (the target population in the 1970's) emphasis on family values. As the Center reached out to many different Hispanic populations in the 1980's and to African Americans in the 1990's, the emphasis on the importance of families remained consistent. Minority groups in the United States generally place great value on their natural reference group (e.g., family, extended network, or tribe).

Target Population

BSFT targets children and adolescents between the ages of 8 and 17 who are displaying or are at risk for developing behavior problems, including substance abuse. BSFT has been implemented as a prevention, early intervention, and intervention strategy for delinquent and substance-abusing adolescents.

Theoretical Underpinnings

The goal of BSFT is to improve youth behavior by:

- Improving family relationships that are presumed to be directly related to youth behavior problems.
- Improving relationships between the family and other important systems that influence the youth (e.g., school, peers).

To understand the specific way in which BSFT produces changes in these relationships and subsequent changes in behavior problems, it is necessary to understand some of the basic principles on which BSFT is based.

Systems

BSFT assumes that each family has its own unique characteristics and properties that emerge and are apparent only when family members interact. This family "system" influences all members of the family. Thus, the family must be viewed as a whole organism rather than merely as the composite sum of the individuals or groups that compose it. In BSFT, this view of the family system is evident in the following assumptions:

- The family is a system with interdependent/interrelated parts.
- The behavior of one family member can only be understood by examining the context (i.e., family) in which it occurs.
- Interventions must be implemented at the family level and must take into account the complex relationships within the family system.

Structure

BSFT also focuses on "structure." While the concept of a system is useful, one must understand the system's basic structure to recognize the mechanism through which it operates. Thus, as noted above, the existence of a system explains how the behaviors of family members are interdependent. These interdependent or linked behavioral interactions among individuals tend to recur and create patterns of interactions among family members. In BSFT, these repetitive patterns compose a family system's structure. This view of structure is evident in the following assumptions:

- Structure refers to the repetitive patterns of interactions that characterize the family system.
- Repetitive interactions (i.e., ways family members behave with one another) are either successful or unsuccessful in achieving the goals of the family or its individual members.
- BSFT targets repetitive patterns of interaction (i.e., the habitual ways in which family members behave with one another) that are directly related to the youth's behavior problems.

Strategy

BSFT believes in a strategic approach that uses pragmatic, problem-focused, and planned interventions. This strategic approach emerged from an explicit focus on developing an intervention that was quick and effective in eliminating symptoms. In BSFT, this strategic approach is evident in the following assumptions:

- Interventions are practical. That is, interventions are tailored to the unique characteristics of families and are implemented to achieve attainable treatment goals.
- Interventions are problem focused. A problem-focused approach targets first those patterns of interactions that most directly influence the youth's psychosocial adjustment and antisocial behaviors and targets one problem at a time.
- Interventions are well planned, meaning that the therapist determines what seem to be the maladaptive interactions (i.e., interactions that are directly related to the youth's behavior problems), determines which of these might be targeted, and establishes a plan to help the family develop more effective patterns of interaction.

Process Versus Content

As noted above, BSFT is primarily concerned with identifying and ameliorating patterns of interaction in the family system that are presumed to be directly related to behavioral symptoms. This focus on patterns of interactions is also referred to as a "process" focus. Rather than focusing simply on what happens in the family (e.g., what dad said when he yelled at the children), BSFT focuses on how interactions occur (e.g., who was involved in the conflict, when it occurred, who responded to whom, what preceded and followed the

incident). This important distinction between process (patterns of interaction) and content (specific and concrete information) is a fundamental concept of BSFT. This process focus is evident in the following assumptions:

- Process refers to what behaviors are involved in an interaction and how they occur. Secondarily, process refers to the message that is communicated by the nature of interactions or by the style of communication, including all that is communicated nonverbally, such as emotion, tone, and the underlying power relationship.
- Content refers to the specific and concrete facts used in the communication. Content includes such things as the reasons that family members offer for a given interaction.
- BSFT is process oriented at all times. The emphasis is on identifying the nature of the interactions in the family and changing those interactions that are maladaptive.

Components of Intervention

There are three intervention components in BSFT: joining, diagnosis, and restructuring.

Joining

Individuals from families that include youth with behavior problems are very difficult to engage in treatment. For the past 15 years, the Center's staff have focused explicitly on family resistance and have developed specialized procedures for engaging families in treatment. These procedures, which are described in more detail below (see "Engaging Hard-To-Reach Families" on page 8), are based on two fundamental assumptions:

- Engagement or joining begins from the very first contact with the family.
- Resistance can be understood in the same way as any other pattern of family interaction.

In BSFT, joining occurs at two levels. First, at the individual level, joining involves establishing a relationship with each participating family member. Second, at the level of the family, the therapist joins with the family system to create a new therapeutic system. Joining thus requires both sensitivity and an ability to respond to the unique characteristics of individuals and quickly discern the family's governing processes.

A number of specific techniques can be used to join the family, including maintenance (e.g., supporting the family's structure and entering the system by accepting their rules that regulate behavior), tracking (e.g., using what the family talks about (content) and how their interactions unfold (process) to enter the family system), and mimesis (e.g., matching the tempo, mood, and style of family member interactions).

Diagnosis

In BSFT, diagnosis refers to identifying interactional patterns (structure) that allow or encourage problematic youth behavior. In other words, diagnosis determines how the nature and characteristics of family interactions (how family members behave with one another) contribute to the family's failure to meet its objective of eliminating youth problems. To derive complex diagnoses of the family, therapists carefully examine family interactions along five interactional dimensions (see the table on pages 6 and 7): structure, resonance, developmental stage, identified patient, and conflict resolution.

Assessment refers to the systematic review of the detailed or molecular aspects of family interaction to identify specific qualities in the patterns of interaction of each family along the five dimensions presented in the table. In contrast, clinical formulation refers to the process of integrating the information obtained through assessment into larger patterns or processes that characterize the family's interactions. In family systems therapy, clinical formulation explains the patient's presenting symptom in relationship to the family's characteristic patterns of interaction. For example, a child's acting out may be seen as resulting from a lack of parental supervision and monitoring that, in turn, are influenced by a poor marital relationship and disagreement about parenting practices.

In addition to the family interactional factors that are central to BSFT, individual and social factors must be considered for a complete clinical formulation. At the individual level, psychological factors (e.g., beliefs, attitudes, intelligence, and psychopathology) and biological factors (e.g., family predisposition toward alcohol abuse or bipolar disorder) must be considered when evaluating the impact of family interactions on the problems experienced by youth. Moreover, other social systems that the family comes into contact with may have a profound impact on the family, and consequently, must be considered in the clinical formulation. For example, youth interactions at school or with peers and the nature of the neighborhood may serve as powerful risk or protective factors. In addition, one's parents, extended family, friends, or career may serve as sources of strength or stress that may or may not contribute to the problems experienced by the youth.

Restructuring

As therapists identify what a family's patterns of interaction are and how these fit with individual and social factors, they make judgments about the relationship between the family's pattern of interactions and the youth's problem behaviors. Based on these judgments, therapists develop specific plans for changing the family interactions and individual and social factors that are directly related to the child's problem behavior. The ultimate goal of treatment plans in BSFT is to change family interactions that maintain the problems to more effective and adaptive interactions that eliminate the problems. BSFT therapists use a range of techniques that fall within three broad categories:

- Working in the present.
- Reframing.
- Working with boundaries and alliances.

Working in the present. While some types of counseling focus on the past, BSFT focuses primarily on the present interactions that occur between family members and are observable to the therapist. For example, enactments are a critical feature of BSFT. Enactments encourage, help, and/or allow family members to behave or interact as they would if the therapist were not present. Very frequently, family members will spontaneously behave in their typical way when they fight, interrupt, or criticize one another. Therefore, when families become rigidly focused on speaking to the therapist, the therapist should systematically redirect communication to encourage interactions between session participants.

There are two reasons for encouraging enactments. The first is to permit the therapist to observe problematic interactions directly rather than relying on stories about what happens when the therapist is not present. Clinical experience shows that families' stories about how they interact are often very different from their actual interactions.

The second reason for enactments, and a central tenet of BSFT, is that the therapist is responsible for restructuring (or transforming) interactions. Frequently,

interactions are transformed when the therapist allows family members to interact and then intervenes in the midst of these interactions to facilitate the occurrence or emergence of a different, more positive set of interactions. It is important to remember that in BSFT, therapists are not interested in having the family simply "talk about" behaving differently. Rather, they are interested in having the family behave differently during and following the intervention sessions.

Reframing. Perhaps one of the most interesting, useful, subtle, and powerful techniques in BSFT is reframing. Reframing creates a different sense of reality; it gives family members the opportunity to perceive their interactions or situation from a different perspective. Reframing is a restructuring technique that typically does not cause the therapist to lose his or her rapport with the family. For this reason, reframing should be used liberally throughout the treatment process, especially at the beginning of treatment when the therapist needs to bring about changes but is still in the process of building a working relationship with the family. Reframing serves two extremely important functions. First, it is a tool for changing negative and apparently "uncaring" emotions into positive and caring interactions. This is achieved, for example, by redefining anger and frustration as the bonds that tie a family together; the therapist may help a parent recognize that his or her anger toward a child is based on love. The other important function is to shift from a blaming or castigating approach to developing a team spirit that allows family members to acknowledge that they are in therapy because they care about one another. One major goal of all restructuring interventions is to create the opportunity for the family to behave in constructive new ways. That is, when the family is unable to break out of its maladaptive interactions, the therapist's job is to help the family interact in a new, more positive, way.

Working with boundaries and alliances. The lives of youth who use drugs are likely to include a complex set of alliances that require intervention. The alliances between the drug user and other users and sellers need to be severed, and alliances with individuals who can encourage prosocial behaviors need to be established.

Boundaries are the social "walls" that exist around groups of people who are allied with one another and that stand between individuals and groups that are not allied with one another. Shifting boundaries refers to changing the patterns of alliance. A common situation of drug-using youth is a strong alliance with only one parent. The resulting alliance may cross generational lines and work against the traditional parental hierarchy. For example, there may be a strong bond between a youth and her or his mother (or mother figure). Whenever the youth is punished by the father (or father figure) for inappropriate behavior, the youth may solicit sympathy and support from the "mother" to undermine the "father's" authority and remove the sanction. In a single-parent family, it may be the grandmother who overprotects the youth and undermines the parent's attempts at discipline. Shifting of boundaries involves:

- Creating a more solid bond between the parents so they will make executive decisions together.
- Removing the inappropriate parent-child alliance and replacing it with an appropriate alliance between both parents or parent figures and the youth that meets the youth's needs for support and nurturance.

Implementation

Philosophy

BSFT is based on the assumption that the family—one of the most important and influential systems in the lives of children and adolescents—provides the foundation for child development. As a result, BSFT conceptualizes and intervenes to change youth behavior problems at the family level. Although BSFT also uses unique interventions to work with individual family members (see "One-Person Family Therapy" on page 7), it attempts to include the entire family in treatment. In fact, therapists are very active in trying to engage reluctant family members, particularly during the early phase of therapy. The basic philosophy is that therapists will be able to understand family problems and treat youth behavior problems more effectively if they view the family's patterns of interaction directly.

Although BSFT therapists are active and directive, they never do what the family members can do for themselves. The therapist's goal is to move in and out of family interactions, creating opportunities in the session that will propel the family's interactions in a new, more positive direction. Even in these circumstances, the therapist moves briefly into a centralized role and quickly moves out of it. Ideally, when the therapist leaves the system, the family will be able to respond positively to internal and external challenges. Exceptions are allowed when crises occur or when situations arise that require expert intervention (e.g., suicidal thoughts or behaviors, family violence/abuse).

A fundamental assumption of BSFT is that families enter treatment with their own, naturally occurring, informal networks, including friends, extended family members, schools, and work. BSFT therapists examine these networks to identify potential problems or areas of strength on which to capitalize in therapy. Thus, rather than attempting to hook family members into formal systems, like social services, that tend to be transient in nature, BSFT tries to improve naturally occurring relationships so the family is more likely to maintain positive changes when the therapist (or social

Dimensions of Family Functioning* Addressed in Brief Strategic Family Therapy

Structure		Resonance
Hierarchy/Leadership One parent is more active than the other. Child is more powerful than the parents. **Behavior Control** Parents are not engaging in behavior control when needed or are engaging in ineffective behavior control (e.g., inappropriate consequences, lack of followthrough, unclear expectations, inconsistency, or excess emotion). **Guidance/Nurturance** Parents do not nurture children. Parents are poor role models (e.g., engaged in illegal activity, substance abuse, or violence). **Spousal Alliance** Marital relationship is poor (e.g., high conflict or disengagement).	**Executive Subsystem** Decisionmaking subsystem is absent. **Sibling Subsystem** Relationship between siblings is poor (e.g., high conflict or disengagement). **Triangulation** Child is stuck in the middle of a conflict between adults. **Communication** Family lacks direct verbal communication or uses ineffective communication (e.g., vagueness, sermonizing, or excess emotion). One family member serves as a switchboard operator or gatekeeper.	**Enmeshment** Emotional, psychological, or physical boundaries between family members are excessively close. **Disengagement** Emotional, psychological, or physical boundaries between family members are excessively distant.

* Examples of problems in family interaction are listed under each of the five dimensions.

services agency) is no longer involved with the family.

Length of Treatment

BSFT is a short-term, problem-focused intervention. The average treatment includes approximately 12–15 sessions and lasts about 3 months. For more severe cases, such as substance-abusing adolescents, the average number of sessions and length of treatment may be doubled. It is important to note, however, that BSFT is not a fixed "package." Treatment continues until the family achieves changes in key behavioral criteria rather than until it completes a predetermined number of sessions.

Location of Treatment

Most BSFT work with children with behavior problems occurs in the office. However, some treatment of substance-abusing adolescents and their families is conducted in the home or community. The movement to "home-based" treatment results from many factors: therapists must deal with families that are highly disorganized and/or unmotivated to attend treatments and families that lack the necessary resources (e.g., transportation, money) to make it to the office. BSFT does not believe that home- or community-based treatment is required for all youth with behavior problems, but finds that it may be required for more severe cases. Therapists should never allow the location of treatment (e.g., home, office, schoolyard) to become an obstacle to treatment.

Development of a Culturally Specific Family Approach

Applying BSFT to Hispanic families revealed how profoundly the process of immigration and acculturation could affect the family and each member. To meet this challenge, an intervention was specifically designed to address the special stressors and clinical problems faced by this population.

Bicultural Effectiveness Training

The Center for Family Studies developed the bicultural effectiveness training intervention to enhance bicultural skills in all family members. Bicultural effectiveness training is specifically designed to ameliorate the acculturation-related stresses confronted by two-generation immigrant families (Szapocznik et al., 1984).

A clinical trial[1] investigated the relative effectiveness of bicultural effectiveness training in comparison with BSFT (Szapocznik, Santisteban, et al., 1986b) in improving behavior problems in early adolescence and family functioning. (Drug-abusing adolescents were excluded from this study because they were considered beyond the reach of the intervention.) The results of this study indicated that bicultural effectiveness training was as effective as structural family therapy in improving adolescent and family functioning. These findings suggested that bicultural effectiveness training could accomplish the goals of family therapy while focusing on the cultural content that made the therapy attractive to Hispanic families.

Family Effectiveness Training

Subsequently, BSFT and bicultural effectiveness training were combined into a

[1] This study was funded by National Institute of Mental Health (NIMH) grant #MH31226.

Developmental Stage	Identified Patient	Conflict Resolution
Parenting Parent is immature. **Children** Child is treated as/acts too young (e.g., overly restricted, low requirement/opportunity for responsible behavior, or no negotiation allowed). Child is treated as/acts too old (e.g., overloaded with adult tasks or exhibits parentlike behavior). **Extended Family** Extended family usurps parental power or treats the parent like a child.	**Negativity** Family members are critical about and negative toward the identified patient. **Centrality** Identified patient is almost always the central topic of conversation. Family members are organized around the identified patient and her/his problem behaviors. **Support** Family members protect or support identified patient.	**Denial/Avoidance** Family members deny or avoid conflict. **Diffusion** Family members jump from conflict to conflict without achieving any depth regarding one particular issue. **Emergence Without Resolution** Family engages in an indepth discussion about a particular conflict but is not able to resolve the problem. **Negativity/Conflict** Family interactions are openly critical or hostile.

package called family effectiveness training (Szapocznik, Santisteban, et al., 1986a). A study[2] investigated the value of family effectiveness training as a prevention/intervention strategy for Hispanic families of children ages 6–11 who presented emotional and behavioral problems (Szapocznik, Santisteban, et al., 1989). The results of this study indicated that families in the family effectiveness training treatment group showed significantly greater improvement than did control families on measures of family functioning, problem behaviors, and child self-concept. Thus, the intervention was able to improve both child and family functioning. The improvements were still in effect at 6-month followup.

Multicultural Effectiveness Training

Recently, the cultural context in Miami has become more complex. When bicultural effectiveness training and family effectiveness training were developed in the 1970's, the targeted Cuban-born families lived in a cultural context that was dominated by Cuban immigrants and Caucasian Americans. However, by the 1990's, Miami included Cuban Americans, Cuban immigrants, Caucasian Americans, Latin Americans from nearly all countries in the Western Hemisphere, African Americans, and Haitian immigrants. In response to these changes, the bicultural effectiveness training intervention was redesigned into the multicultural effectiveness training (Mancilla and Szapocznik, 1994) program that helps non-Cuban Hispanic parents understand the complex cultural context in which they live. In multicultural effectiveness training, the challenges faced by non-Cuban Hispanic families who find themselves in a culture that is heavily influenced by Cuban Americans are considered for the first time.

One-Person Family Therapy

Engaging the whole family in treatment is one of the most challenging aspects of working with youth with behavior problems and their families. Thus, developing a procedure that can achieve the goals of family therapy without having the whole family present was an important challenge.

To meet this challenge, it was necessary to question some basic theoretical assumptions of conventional family systems practice. Family systems theory postulates that the youth's behavior problems are a symptom of flawed patterns of family interaction. As such, interventions must change family interactions that produce problem behaviors in the child. Conventional family systems theorists assume that to change these interactions, the entire family must be present in therapy. Thus, the challenge involved developing an approach, One-Person Family Therapy, that seeks to change family interactions while working with only one person (Szapocznik, Kurtines, et al., 1990; Szapocznik and Kurtines, 1989).

One-person family therapy applies the principle of complementarity, which suggests that a change in the behavior of one family member will lead to corresponding changes in the behavior of other family members. One-person family therapy uses this principle deliberately and strategically to direct the identified patient to change his or her behavior in ways that will lead to

This study was funded by National Institute on Drug Abuse (NIDA) grant #1E0702694.

adjustments in the behavior of other family members toward him or her.

A clinical trial[3] examined the effectiveness of one-person family therapy, comparing the entire family format with the one-person format of BSFT (Szapocznik, Kurtines, et al., 1983, 1986). Both conditions were designed to use the BSFT framework so that only the number of people would differ. Results indicated that one-person family therapy was as effective as the group format not only in improving behavior and reducing drug abuse in the youth, but also in improving and maintaining significant improvements in family functioning. The results of this study demonstrated that it is possible to change family interactions even when the whole family is not present at most sessions. It is important to note, however, that one-person family therapy was most effective when it was implemented by expert BSFT therapists. To implement one-person family therapy, therapists must be proficient with family and individual BSFT techniques. One-person techniques are very complex and sophisticated and thus require a therapist with extensive training and experience in changing family interactions.

Engaging Hard-To-Reach Families

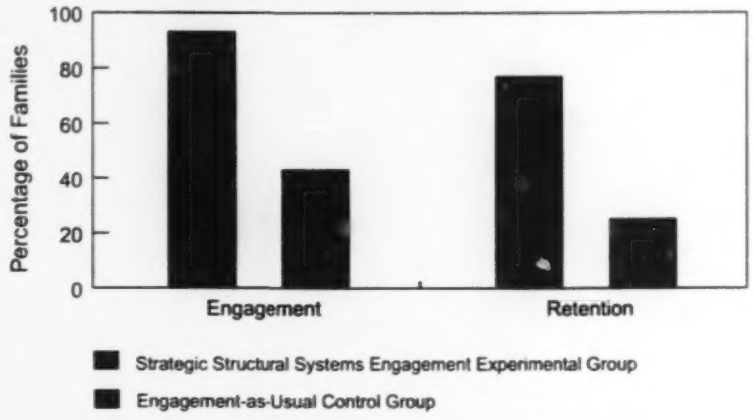
Although it is possible to conduct family therapy through one person, getting individuals to begin treatment continues to be a problem. For example, in the clinical trial discussed above, only 250 of approximately 650 families who met intake criteria on the basis of a telephone screening began the intake process. Of this number, 145 completed the intake procedure and only 72 completed treatment. Clearly, a very large proportion of families who initially seek treatment never participate in therapy.

Strategic Structural Systems Engagement

Strategic structural systems engagement was developed to more effectively engage drug abusers and their families in treatment (Szapocznik, Perez-Vidal, et al., 1990; Szapocznik and Kurtines, 1989). It is based on the premise that resistance to change within the family results from two systems properties. First, the family is a self-regulatory system—that is, the family will attempt to maintain structural equilibrium (status quo) which, in the case of drug-abusing youth with behavior problems, can be accomplished by avoiding therapy. Second, while the presenting symptom may be drug abuse, the initial obstacle to change is resistance to treatment. The same structural principles that apply to family functioning and treatment also apply to understanding and handling the family's resistance to treatment (Szapocznik, Perez-Vidal, et al., 1990). The solution to overcoming the undesirable "symptom" of resistance is to restructure the family's patterns of interaction that permit the symptom of resistance to continue to exist. It is here that one-person family therapy techniques become useful because the person requesting help becomes the person through whom therapy can work to improve the family's pattern of interaction. Having accomplished the first phase of the therapeutic process in which resistance has been overcome and the family, including the drug-abusing youth, have agreed to participate in therapy, the therapist may shift the focus of the intervention toward the removal of behavior problems and drug abuse.

Clinical work suggests that the patterns of interaction that permitted the symptoms to exist may be the same patterns of interaction that keep the families from entering treatment. Hence, to have the opportunity to intervene in these hard-to-reach families, the therapist using strategic structural systems engagement must begin the intervention with the first phone call rather than the first office session.

Figure 1: Differential Engagement and Retention Rates for Strategic Structural Systems Engagement Experimental Group and Engagement-as-Usual Control Group



To test the effectiveness of strategic structural systems engagement in engaging and retaining Hispanic families with drug-abusing youth in treatment, a major clinical trial[4] was conducted (Szapocznik, Perez-Vidal, et al., 1988). In this study, strategic structural systems engagement was compared to an engagement-as-usual control condition. Clients in the control condition were approached in a way that resembled as closely as possible the kind of engagement that usually takes place in outpatient centers. There were two basic findings from the study (Szapocznik, Perez-Vidal, et al., 1988). First, as figure 1 shows, the effects of the experimental condition were dramatic. More than 57 percent of the families in the engagement-as-usual condition failed to participate in treatment. In contrast, only 7.15 percent (four families) in the strategic structural systems engagement condition failed to participate in treatment. The differences in the retention rates were also dramatic. In the engagement-as-usual condition, 41 percent of cases did not complete treatment; whereas, in the treatment condition, 17 percent of cases did not complete treatment. Thus, of all cases assigned to therapy, 25 percent in the engagement-as-usual condition and 77 percent in the strategic structural systems engagement condition were successfully completed. For families that completed treatment in both conditions, behavioral improvements

[3] This study was funded by NIDA grant #DA0322.

[4] This study was funded by NIDA grant #DA2059.

by adolescents were highly significant and these improvements were not significantly different across the engagement conditions. The critical distinction between the conditions was in the rates of participation and completion.

A second major finding of the project (Szapocznik et al., 1988) was the identification of a number of resistant family types and the development of intervention strategies for engaging these families (Szapocznik and Kurtines, 1989).

Replication Study

An additional study[5] was designed to replicate these findings and to further explore the elements of effective interventions (Santisteban et al., 1996). This study, which included a large multicultural sample, demonstrated the overall effectiveness of the specialized engagement interventions discussed above. Significant differences in rates of engagement were found between the treatment group and the control group. In the treatment group, 81 percent of the families were successfully brought into treatment. In contrast, 60 percent of the families assigned to the two control groups were successfully brought into treatment.

In addition to investigating the overall effectiveness of the specialized engagement intervention, the study also investigated the influence of culture/ethnicity on the multicultural Hispanic sample. The data suggested varying rates of engagement across Hispanic groups. Among the non-Cuban Hispanics (primarily Nicaraguan, but also including Colombian, Puerto Rican, Peruvian, and Mexican) assigned to the treatment group, the rate of intervention failure was extremely low (3 percent). Fully 97 percent of the non-Cuban Hispanic families were successfully treated. In contrast, among the Cuban Hispanic sample assigned to the treatment group, the rate of intervention failure was relatively high at 36 percent, with 64 percent of the Cuban Hispanic families successfully treated.

Comparing Structural Family Therapy With Other Types of Therapy

Earlier research concentrated on the development, refinement, and testing of BSFT theory and strategies. The next challenge was to compare the relative effectiveness of BSFT with that of other widely used clinical interventions. Two such studies are described below.

BSFT Versus Individual Psychodynamic Child Therapy

The first study[6] compared the effectiveness of a structural family therapy group (Minuchin, 1974; Minuchin and Fishman, 1981) with an individual child therapy group and a recreational activity control group for children with behavior problems. In addition, this study investigated the mechanisms for change used by each type of therapy. Both theoretical approaches assume underlying causes of symptoms and try to eliminate or reduce symptoms. However, each form of therapy uses a different approach to reducing symptoms. The individual child approach postulates that the child's internal (i.e., emotional, cognitive) functioning needs to be modified to eliminate the symptoms. BSFT, on the other hand, postulates that family interactions need to be modified to eliminate the symptoms. Because of these important theoretical differences, this study explored the impact of each form of therapy on child psychodynamic functioning and family interactions.

The analysis revealed several important findings. First, members of the recreational activity (control) group were significantly more likely to drop out than members of the two treatment conditions, with more than two-thirds of dropouts belonging to the control group. Second, the two forms of therapy were equally effective in reducing behavior and emotional problems.

A third finding demonstrated the greater effectiveness of BSFT over child therapy in protecting family integrity in the long term (see figure 2). In this study, psychodynamic therapy was found to be effective in reducing symptoms and improving child psychodynamic functioning, but it was also found to result in undesirable deterioration of family interactions. The findings supported the BSFT assumption that treating the whole family is important because it reduces the symptoms and protects the family, versus treating just the child, which may cause family interactions to deteriorate.

Structural Family Therapy Versus Group Counseling

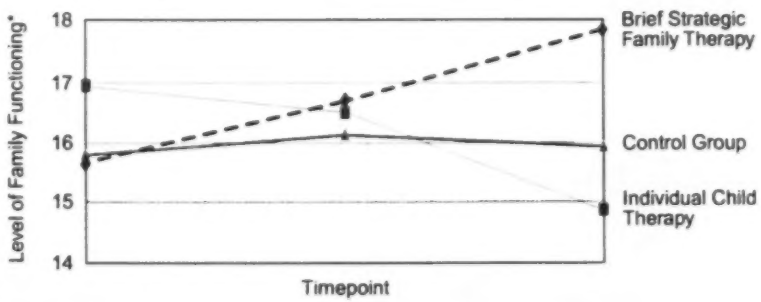
A second clinical trial compared the effectiveness of BSFT with that of a control condition delivered in a group format (Santisteban et al., 1996). This study also investigated whether changes in family functioning were responsible for the changes observed in youth behavior.

Youth who received BSFT showed significantly greater improvement in behavior ($p<.05$) than youth assigned to group counseling. In fact, youth in BSFT showed significant improvements in conduct disorder and socialized aggression, while youth in group counseling did not.

[5] This study was funded by NIDA grant #DAO5334.

[6] This study was funded by NIMH grant #DA34821.

Figure 2: Comparison of Family Functioning at Pretest, Posttest, and 1-Year Followup for Youth Assigned to Brief Strategic Family Therapy, Individual Child Therapy, and Recreational Control Group



Note: The three points on each line designate the following events: pretest, posttest, and 1-year followup, in that order.

*Numbers on this axis reflect the family's functioning on five dimensions of family interaction. Higher numbers represent healthier, more adaptive family functioning.

A Structural Approach to Changing the Social Context of Families

As the needs of families change, the theoretical and clinical work of the Center for Family Studies continues to evolve. The Center has expanded and adjusted its interventions in response to declining inner-city social conditions, the multiple problems faced by minority families, and the complex contextual factors that affect behavior problems. The Center is developing a structural approach for changing the social context of families that works more effectively with minority youth with behavior problems and their families.

Theoretical Background

The Center for Family Studies uses the theoretical work of Bronfenbrenner (1977, 1979, 1986) and the multisystemic, service-oriented approach of Henggeler and colleagues (Henggeler and Borduin, 1990; Henggeler, Melton, and Smith, 1992). Bronfenbrenner examined the complexity of contexts, especially the relationships between various systems that affect an individual. In doing so, he identified and defined "microsystems" as those systems that have direct contact with the individual. For a child, microsystems include the family, school, and peers. He defined "mesosystems" as those systems that occur when microsystems interact. One example of a mesosystem occurs when the parents and school collaborate on a child's education. Another example of a mesosystem occurs when parents and peers interact (e.g., when parents organize and supervise peer activities). "Exosystems" are defined as those systems that affect family members and, through their impact on family members, affect the child. Examples of exosystems are a mother's workplace or her natural support network.

Bronfenbrenner's theory highlights the pivotal role of context in the life of a child and her or his family members. Moreover, this theory helps to explain how culture influences all other social contexts and provides a framework for developing culturally sensitive interventions that take into account the complex influence that cultural factors have on minority families.

Most of the current work at the Center for Family Studies reflects an increasing understanding of ecosystemic influences on youth behavior problems. In fact, several ongoing ecosystemic prevention and intervention projects are being implemented in schools and neighborhoods to address children's behavior problems. In place of a review of each of these programs, one program that exemplifies the ecosystemic philosophy is described below.

The Family Alliance Project.[1] The Family Alliance Project study is investigating the effectiveness of ecosystemic family therapy compared with traditional family therapy and a community control group. The experimental intervention, structural ecosystems therapy, organizes the life context of the drug-abusing youth using Bronfenbrenner's social ecology framework and the theoretical principles of BSFT—that is, patterns of interaction are examined within and outside the family. Structural ecosystems therapy includes a full dose of BSFT (e.g., alliance, hierarchy, communication flow, personal and subsystem boundaries, developmental stage, identified patient, conflict resolution style, and abilities). However, interventions go beyond the family to target other critical youth interactions. In particular, the youth's relationships with school authorities and prosocial versus antisocial peers are examined. At the mesosystem levels, the relationships between parents and school, parents and their children's peers, and parents and the juvenile justice system are considered. At this mesosystem level, the extent to which the different systems support one another, or are in conflict with one another, is critical. For example, in the parents-peers mesosystem, parents may know the peers, organize supervised peer activities, and know the parents of their child's peers. Parents may participate in community organizations that provide organized, supervised peer activities.

Results of the interventions suggest that it is possible to affect youth conduct problems at home and school by correcting patterns of interaction in the family and school microsystems and the family-school mesosystem; reducing youth drug abuse also requires improving interactions in the peer microsystem and family-peer mesosystem.

[1] This study was originally funded as a treatment development project by Center for Substance Abuse Treatment grant #1 HD7 T100417; it is currently funded by NIDA grant #1 RO1 DA10574.

Conclusion

In the evolution of BSFT, the Center for Family Studies has sought to integrate theory, application, and research. The Center's work began in the 1970's to address an issue of growing concern: promoting culturally competent therapists and therapies to address behavior and drug abuse problems among Miami's Hispanic youth. Since then, the Center has achieved important breakthroughs in assessment, engagement, treatment, and prevention, which have provided a solid foundation from which to pursue new advances in the field. Refinement of structural family theory strategies and goals in BSFT, in turn, enabled the Center to modify these strategies to achieve the same goals without having the entire family in therapy, thus making one-person family therapy possible. Changing family interactions by working primarily with one person led to a breakthrough in engaging hard-to-reach families in treatment.

The work of the Center for Family Studies will help therapists develop new strategies to support minority families. As the needs of families change, work in the field needs to continue to evolve to address the multiple problems minority families will continue to confront. The Center operates under the assumption that "it takes a village to raise a child." It is necessary both to create a "village," or community, that can support healthy child development and to modify policies and systems that provide services to the community. Bronfenbrenner (1979) wrote, "Seldom is attention paid to the person's behavior in more than one setting or to the way in which relations between settings can affect what happens within them" (p. 18). He suggested that an individual's environment is composed of a complex set of nested structures. Scientists involved in intervention must consider the social and cultural context in which treated families live. The Center for Family Studies' development of theory, research, and services within the complex community is based on this priority.

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